



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC & SPINE HOSPITAL
5420 WEST LOOP SOUTH STE 3600
BELLAIRE TX 77401

Respondent Name

State Office of Risk Management

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-3275-01

MFDR Date Received

July 2, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because CPT is for a revision only."

Amount in Dispute: \$19,197.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has failed to submit a claim correcting the CPT code to reflect the procedure being performed as an outpatient procedure."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2011	Outpatient Hospital Services	\$19,197.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 24, 2012

- 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.
- 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.

- W1 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- 125 – PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S).
- 198 – PAYMENT DENIED/REDUCE FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION.

Explanation of benefits dated June 11, 2012

- 5 – THE PROCEDURE CODE/BILL TYPE IS INCONSISTENT WITH THE PLACE OF SERVICE.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- W1 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 198 – PAYMENT DENIED/REDUCE FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed surgical services billed under procedure code 27486 with reason code 198 – "PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION and 5 – THE PROCEDURE CODE/BILL TYPE IS INCONSISTENT WITH THE PLACE OF SERVICE ." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." No documentation was found to support a medical emergency, nor was any documentation found to support that this surgical service billed under code subject to inpatient rules had been preauthorized. Procedure code 27486 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting. The insurance carrier's denial reasons are supported. Reimbursement for procedure code 27486 is not recommended.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless separate reimbursement of implantables is requested in accordance with subsection (g). Subsection 134.403(g)(1) requires that a provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. Although separate reimbursement for implantables was requested, review of the submitted documentation found no such certification of the actual cost. The Division concludes that the facility has not requested separate reimbursement of implantables in accordance with subsection (g); therefore, separate reimbursement of implantables cannot be recommended.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the

applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.91. 125% of this amount is \$14.89

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.67
- Procedure code 87081 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.33. This amount multiplied by 11 units is \$102.63. 125% of this amount is \$128.29. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of \$76.68. The lesser amount is \$76.68.

4. The total allowable reimbursement for the services in dispute is \$108.99. This amount less the amount previously paid by the insurance carrier of \$1,773.73 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 26, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.